10 – Preauthorization

Overview

Definitions

Preauthorization is the determination of the medical necessity and appropriateness of treatment as a required part of the Utilization Management process for certain covered services. Preauthorization may also be referred to as prior authorization, prior approval or precertification. Failure to obtain these proper permissions may affect claim payment, subject to the terms and conditions of a Coverage Plan. A preauthorization is not a guarantee of benefits or payment.

Predetermination is a voluntary, written request for review of treatment or services and includes services that may be considered: not medically necessary; investigational, experimental or unproven; or cosmetic. Predetermination approvals and denials are usually based on provisions in our medical policies. A predetermination of benefits is not a substitute for a preauthorization.

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10.1 Obtaining Preauthorization

**Requesting Preauthorization**

Participating Providers are required to request preauthorization on the member's behalf in accordance with the member's evidence of coverage; failure to do so may result in denial of the provider’s claim and the member cannot be balance billed. Providers should complete the Preauthorization Request form located in the attachments at the end of this section, and in the Forms section on our website. This form provides us with the necessary information to efficiently process requests.

- Preauthorization may also be requested by calling the preauthorization phone number listed on the back of the member’s ID card.
- If you are faxing or mailing in a request, please submit the completed form along with your supporting documentation.
- **Behavioral health services**, authorizations, benefits and eligibility information must be obtained by calling 888-898-0070. For further information see Section 12, Behavioral Health Services, and on our website under the Clinical Resources tab.
- iExchange may also be used for any inpatient or outpatient requests. This is an online precertification and concurrent review tool that allows facilities and admitting physicians to request, view, extend, and ultimately manage cases in real time. This free functionality does not require any additional software.

The BCBSNM’s Intake Unit will:
- assign a reference number to the request for service
- certify a request for service if appropriate
- transfer the request for service to the Medical Management department as indicated

The Medical Management (MM) department will:
- evaluate the appropriateness of the admission and level of care using Milliman Care Guidelines (MCG) criteria and medical policy as indicated,
- certify a projected length of stay, and
- assist with identification of in network providers as indicated

MM personnel will endeavor to respond within the time frames afforded by applicable law.
10.1 Obtaining Preauthorization, Continued

Requesting Preauthorization, Continued

Most BCBSNM plans exclude reimbursement for services or do not allow for reimbursement where preauthorization is required and has not been obtained. To avoid claim denial for lack of preauthorization, providers and members must comply with the member’s benefit plan requirements for preauthorization.

**Note:** Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment of a particular service, that authorization applies only to the medical necessity of treatment and may be rescinded if the preauthorization request and/or supporting documentation is fraudulently or materially deficient or misleading, whether by commission or omission. Furthermore, coverage remains subject to all applicable limitations and exclusions, including those set forth in laws, the provider’s participation agreement with BCBSNM (including this Manual), and the member’s evidence of coverage.

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Medicaid and Medicare Requirements

Medicaid Preauthorization Requirements – Refer to the Blue Cross Community CentennialSM section.

Medicare Preauthorization Requirements – Refer to the Blue Cross Medicare AdvantageSM section.

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Members using Network Facilities

Except for emergency care, HMO and EPO BCBSNM members must select a hospital within the network of contracted BCBSNM facilities. BCBSNM PPO members using network hospitals will receive a higher benefit level than they would if services were rendered in an out-of-network hospital.

If the attending physician has privileges at more than one BCBSNM contracted facility, Customer Service can provide information regarding the most cost-effective facility so the member’s out-of-pocket expenses are minimized.
In the event medically necessary covered services are not reasonably available through professional Participating Providers, you, as a Participating Provider, should make a referral to an out-of-network professional. However, to be covered, referrals for out-of-network provider services for HMO members require preauthorization by BCBSNM. If not obtained, the out-of-network service will not be covered. BCBSNM’s Medical Director must review and approve these referrals before out-of-network services are scheduled or rendered.

These out-of-network referrals will only be preauthorized when a medically necessary covered service is not reasonably available through a Participating Provider.

Before BCBSNM may deny such a referral to an out-of-network physician or health care professional, the request must be reviewed by a specialist similar to the type of specialist to whom a referral is requested.
10.2 Services Requiring Preauthorization

There are conditions for coverage, including, but not limited to, preauthorization for certain services. To be eligible for coverage, Participating Providers must obtain preauthorization for the services listed below (if covered by the member’s plan), except in an emergency. (Excludes FEP and other groups that may have selected additional preauthorization requirements not specified in this document)

As of the date of the last update to this Manual, the following services require preauthorization. Please note that a particular service may not be described or grouped in a way that matches a specific provider's expectations so be sure to broadly and thoroughly key word search this list and call the preauthorization or pre-certification telephone number on the back of the member’s card to confirm.

<table>
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<th>Services Requiring Preauthorization</th>
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<tr>
<td>(Out of Network) Surgical Elective</td>
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<tr>
<td>Advanced Imaging Services-CT, CTA, MRI, MRA, PET, PET/CT, and Nuclear Medicine (except Cardiology)</td>
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<td>Air ambulance services (unless during a medical emergency)</td>
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<tr>
<td>All inpatient medical/surgical admissions – acute care, rehabilitation, skilled nursing facility, long term care facility, and hospice</td>
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<tr>
<td>All behavioral health/chemical dependency admissions (Refer to Section 12 – Behavioral Health Services)</td>
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<tr>
<td>Applied Behavioral Analysis</td>
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<td>Arthroscopic, open and joint replacement surgeries for the shoulder, hip, and knee*</td>
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<tr>
<td>Artificial Intervertebral Disc Surgery</td>
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<td>Autism treatment – treatment plan is required for Applied Behavioral Analysis (ABA), physical, speech and occupational therapies</td>
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<tr>
<td>Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions</td>
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<tr>
<td>Bone Conduction Hearing Aids/Cochlear Implant</td>
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<td>Certain injections, including but not limited to intravenous immunoglobulin (IVIG)</td>
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<td>Deep Brain Stimulation</td>
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<td>Diagnostic sleep studies for Obstructive Sleep Apnea</td>
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<td>Diagnostic US: Head &amp; Neck, Pediatric, Breast, Abdomen &amp; Retroperitoneum, Extremity, Arterial &amp; Venous</td>
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<tr>
<td>DIALYSIS: Dialysis for out of network services only</td>
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<tr>
<td>Ear, Nose, and Throat (ENT): Bone conduction hearing aids, Cochlear implants</td>
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<td>Enteral Nutritional products, special medical foods, and certain drugs covered under the drug plan rider; Prescription refills before the supply should have been exhausted</td>
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<tr>
<td>Epidural Steroid Spinal Injections*</td>
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<td>Femoroacetabular Impingement (FAI) Syndrome</td>
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<td>Facet Joint Spinal Injections*</td>
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<td>Functional Neuromuscular Electrical Stimulation (FNMES)</td>
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<td>Gastroenterology (Stomach): Gastric Electrical Stimulation (GES)</td>
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<td>Home health care and home I.V. services</td>
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<td>Home Hemodialysis</td>
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<td>Home hospice</td>
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<td>Home infusion therapy (HIT), excluding antibiotics</td>
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<td>Hospice</td>
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<td>Implantable Intrathecal Drug Delivery Systems*</td>
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<td>Lumbar Spinal Fusion</td>
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<td>Mastopexy</td>
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<td>Molecular genetic testing**</td>
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<td>Nasal and Sinus Surgery</td>
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<td>Neurological: Deep Brain Stimulation</td>
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<td>Non- Emergency or elective Hospital or other Facility Admissions</td>
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<tr>
<td>Non-Emergency or elective care from a Non-Participating Provider</td>
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<td>Non-Emergency or Elective Hospital or Facility Admissions</td>
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<td>Occipital Nerve Stimulation</td>
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<td>Pain Management: Occipital Nerve Stimulation and Neuromodulation*</td>
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<td>Durable Medical Equipment (DME) Pneumatic Compression Devices *</td>
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<tr>
<td>Positive Airway pressure (PAP) therapy devices and supplies; (Sleep CPAP and BiPAP machines), Positive Airway pressure (PAP) Therapy Compliance Monitoring and Intervention for Non-Compliance</td>
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<td>Prescription Drugs and Other Items</td>
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Prescription Refills: Before the supply should have been exhausted

Pretransplant evaluations

Psychological testing; neuropsychological testing; electroconvulsive therapy (ECT); repetitive transcranial magnetic stimulation, and intensive outpatient program (IOP) treatment

Radiofrequency Spinal Facet Joint Ablation/Denervation*

Radiology: Radiation Therapy**

Reduction Mammoplasty/Breast Reduction

Regional Sympathetic Nerve Blocks*

Requests for out-of-network provider services for HMO members

Sacral Nerve Neuromodulation/Stimulation

Sacroiliac Joint Injections*

Sacroiliac Nerve Injections

Select pharmacy requests (Refer to Section 14 – Pharmacy Services)

Sleep Medicine: Sleep Medicine Attended sleep studies and home sleep testing, Facility based Polysomnography Titration

Spinal Cord Stimulators*

Spinal decompression and fusion surgeries*

Surgical Deactivation of Headache Trigger Sites*

Surgical Procedures: Orthognathic Surgery, Total Disc Replacement Surgery

Transitional Care Benefits

Transplant procedures including pre-Transplant evaluations

Total Disc Replacement Surgery*

Vagus Nerve Stimulation (VNS)

Wound Care: Hyperbaric Oxygen (HBO2) Therapy

The universe of services that must be preauthorized is not static. BCBSNM continuously evaluates which services require preauthorization and which do not. When a service no longer requires an authorization or a preauthorization requirement is added to a service, Participating Providers will be informed by separate communication from BCBSNM and updates to this section will be made in the next upcoming regularly scheduled update. The services above denoted with a single asterisk “*” do not, at the time of the last update to this Manual, require preauthorization but are under consideration for requiring preauthorization. Services denoted with a double asterisk “**” are preauthorized by eviCore for insured commercial and retail products and select self-funded groups. Call the preauthorization or pre-certification telephone number on the back of the member's card to confirm.
Effective 1/1/2018 the Health Advocacy Solutions (HAS) program will require certain care categories preauthorization; for more information regarding services requiring preauthorization for members with HAS, go to the Preauthorization page on bcbsnn.com/provider.

10.2 Services Requiring Preauthorization, Continued

**Length of Stay**
If an extension of the initial length of stay is necessary, Participating Providers must, on behalf of the member, call the Medical Management department at 1-800-325-8334 before the initial approved length of stay expires. Failure to obtain approval for length of stay beyond that which has been approved may result in reduced payment to the provider and the member cannot be balance billed.

10.3 Emergency Care

**Emergency Care**
Emergency services to screen and stabilize the patient are a benefit without prior approval. Since the prudent layperson standard applies to members seeking emergency services, the member should dial “911” or go to the nearest emergency room if they believe emergency care is needed.

10.4 Urgent Care

**Urgent Care**
When medically necessary care is provided to the patient in an urgent care facility for an illness or accidental injury, no preauthorization is required.
10.5 Obtaining Predetermination

The predetermination process gives Participating Providers the opportunity to confirm coverage in writing before the requested service is rendered. Predetermination does not, however, guaranty payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility and the terms of the member’s evidence of coverage applicable on the date the service was rendered. Requests for benefit determination can be obtained by submitting a predetermination request.

Examples of predeterminations include:
- outpatient services
- durable medical equipment
- surgeries that might be considered cosmetic
- possible experimental and investigational procedures/treatments

Predetermination of benefits requests may be submitted electronically to BCBSNM through iExchange®. To learn more about iExchange® and other electronic options, visit the Provider Tools section in our online Education and Reference Center. For personalized online training regarding electronic tools, contact our Provider Education Consultants at PECS@bcbsnm.com.

To submit paper predetermination requests, complete the Predetermination Request form and fax or mail it to BCBSNM (fax number and address are on the form).

Important Tips

- **Always** check benefits before submitting a predetermination. A predetermination is not available for all procedures. For example, predetermination may not be available for complete or partial bony impacted teeth.
- Fill out the entire Predetermination Request form.
- Include provider/facility name, address, fax and phone numbers.
- Include ordering physician name, address, fax and phone numbers.
- Provide contact name, address, fax and phone numbers.
- Always provide procedure code(s) and diagnosis code(s).
- If applicable, provide left, right or bilateral.
• Regarding major diagnostic tests, please include the patient’s history, physical and any prior testing information.
• If indicated, include original photos or digital color copies that clearly show the affected area of the body. This information must be mailed to the address indicated on the Predetermination Request form.

10.6 Attachments

- [Preauthorization Request Form](#)
- [Predetermination Request Form](#)